Major Management Challenges

Major Management Challenges Identified by VA's Office of Inspector General

The following is an update prepared by VA's Office of Inspector General (OIG) summarizing the most serious management problems facing VA, and assessing the Department's progress in addressing them. (On these pages, the words "we" and "our" refer to the OIG.)

1. Health Care Quality Management and Patient Safety

One of the most serious challenges facing VA is the need to maintain a highly effective health care quality management program. Although Veterans Health Administration (VHA) managers are vigorously addressing the Department's quality management and patient safety procedures in an effort to strengthen patients' confidence, health care system delivery issues remain. In our ongoing review of VAMC quality management programs, we found that recommended action items resulting from internal investigations or reviews were not always implemented. Without resolution of identified deficiencies, unsafe or improper conditions can continue to pose risks to patients. Local resource issues often compete for priority in developing vigilant quality of care monitoring and performance improvement.

Current Status

In several areas reviewed this year, we found that VHA guidance has lagged behind identified quality management concerns and that guidance issued has not been sufficiently clear and/or implemented. For example, in our April and June 2002 reports titled *Controlled Substances Prescribed to Patients in VHA Mental Health and Behavioral Sciences Programs* (Report No. 01-00026-18) and *VHA Pain Management Initiative* (Report No. 01-00026-101), we found that consistency in pain management has improved; however, the VHA pain management initiative was not implemented across the system for all categories of patients. Similarly, in our February 2002 report titled *Evaluation of VHA Coding Accuracy and Compliance Program* (Report No. 01-00026-68), we found that while adherence to the compliance program has improved, full implementation of all aspects across the system continues to lag. This results in ongoing problems with timely and accurate coding and billing. Functional and resource disparities continue to impede the Department's ability to assess and control clinical practices, and to devise procedures to correct or eliminate problems.

In addition to VA facility monitoring, concerns exist for the care provided to veterans in the private sector, e.g., on a VA contract or fee basis. Patients, their family members, and members of Congress are concerned about patient safety and the quality of care provided in VA contract nursing homes. During our recently completed national review of contract nursing home quality, we found that VA has taken years to fully implement standardized inspection procedures for monitoring contract nursing home activities and for approving homes for participation in the program. We concluded that contract nursing home inspections were not sufficient to ensure that patient safety and quality of care equaled that provided in VA nursing homes. We also found that VA medical center contract nursing home review teams did not use available sources of information such as the Centers for Medicare and Medicaid Services' list of homes

with various problems; as a result, veterans had been placed in several of these homes. We also found that contract nursing home review teams did not meet annually with Veterans Benefits Administration (VBA) fiduciary field examiners to discuss the problems of veterans who are of concern both to VHA and VBA.

In the aftermath of the September 11 terrorist attacks, we reviewed the adequacy of security and inventory controls over selected biological, chemical, and radioactive agents owned by or controlled at VA facilities. In our March 2002 report titled *Review of Security and Inventory Controls Over Selected Biological, Chemical, and Radioactive Agents Owned by or Controlled at Department of Veterans Affairs Facilities* (Report No. 02-00266-76), we found that security measures to limit physical access to research facilities, clinical laboratories, and other high-risk or sensitive areas varied significantly. VHA's inventories of sensitive materials were incomplete and inadequate. In addition, while most facilities had complied with requirements for disaster planning, many had not updated their plans to include terrorist activities. This review also emphasized the ongoing challenge of obtaining adequate and timely credentials and background checks for employees and contractors. In March 2002, the VA Deputy Secretary requested that VHA and Office of Policy and Planning staff implement the recommendations in this report by September 30, 2002. As of September 2002, VHA, in conjunction with the Office of Policy and Planning, had implemented 2 of the 16 recommendations in the report.

The OIG conducted a nationwide assessment of VHA's policies and practices for evaluating and managing violent and potentially violent psychiatric patients. Our March 1996 report titled *Evaluation of VHA's Policies and Practices for Managing Violent and Potentially Violent Psychiatric Patients* (Report No. 6HI-A28-038) recommended that VHA managers explore network flagging systems that would ensure employees at all VAMCs are alerted when patients who have a history of violence arrive at a medical center for treatment. VHA concurred that VISN-level/national databases are needed to support information sharing; however, this recommendation has not been implemented.

VA's Program Response

The VA pain management strategy has been implemented across the system for all categories of patients. The External Peer Review Program (EPRP) data have steadily improved over the past 2 years and monitors have been revised to be more comprehensive. The Joint Commission on Accreditation of Healthcare Organizations' (JCAHO) findings for fiscal years 2000 through 2002 are being tracked to determine pain compliance problem areas that can be addressed. Educational opportunities, media and print materials, toolkits, and clinical practice guidelines are provided to facilities to assist in bringing the entire system into full compliance.

Progress continues in implementing the Coding Accuracy and Compliance Program across the system. The VHA Handbook for Coding Guidelines was published in June 2002. The Web-based Coding Initiative was deployed for use by VA staff in April 2002; current enrollment exceeds 3,000. Electronic encounter forms for primary care and mental health were released in July 2002, and clinical education aids were distributed nationally in August 2002. Additional coding activities under development include revision of the VHA Health Information Management (HIM) Handbook planned for completion in December 2002. Nationally developed documentation templates, additional nationally developed electronic encounter forms, and physician documentation education tools, all were released in September 2002. A satellite broadcast education series, HIM Coding and Documentation for Compliance, is scheduled throughout FY 2003, along with expanded enrollment in the Web-based Coding Initiative to exceed 4,000 VA learners, to meet the continuing education needs of existing coding staff and the educational needs of new coding staff.

A revised Handbook for Community Nursing Home (CNH) Procedures was issued in June 2002 to address oversight of patient safety and

quality of care for patients being provided care in community nursing homes. The handbook specifies instructions for the initial and annual review of both regional and local CNH contracts, and instructions for ongoing monitoring and follow-up visits for veterans placed in both regional and local CNH contract homes. VHA leadership is currently considering additional recommendations from the Inspector General on further improvement to the oversight process. A report and final action by the Under Secretary for Health is anticipated by year's end.

In response to the OIG report, *Review of Security and Inventory Controls Over Selected Biological, Chemical, and Radioactive Agents Owned by or Controlled at Department of Veterans Affairs Facilities*, VHA noted it had issued the *Emergency Management Program Guidebook* in February 2002. This was followed by a memorandum in August 2002, from the then Assistant Deputy Under Secretary for Health, requesting that all field facility management programs be updated to include mitigation/preparedness actions and response/recovery plans for terrorist threats and events according to the Guidebook; that facilities conduct hazard vulnerability analyses (HVA) to ensure that hazardous chemical and biological agents stored in the clinical and research labs or elsewhere at facilities are secure; that all facilities have developed and implemented appropriate mitigation/preparedness activities and plans for response/recovery activities designed specifically for clinical and research labs, or areas in facilities that would house or contain hazardous substances or agents; and that the evaluation and updating of all facility operation plans be conducted annually as required by JCAHO. The annual evaluation includes reviewing and updating standard operating procedures for terrorist threats and events, controlling access to facilities, and conducting an HVA for clinical research labs.

The Office of Research and Development (ORD) has received responses for their request for proposals, dated February 8, 2002, for supplemental funding needed to purchase and install necessary security equipment. ORD is spending more than $2 million to upgrade laboratory security at more than 50 sites, and will systematically review all research sites over the next 3 years as part of its infrastructure program to identify and fund equipment needs that include security devices. ORD issued a memorandum to medical facility directors on security training. Additional guidance is anticipated in the Office of Security and Law Enforcement Handbook 0730, currently being revised. A joint security memorandum, dated July 29, 2002, from VHA and the Office of Security and Law Enforcement in the Office of Policy and Planning, addressed security issues identified in the OIG report recommendations. Guidance from the ORD on procurement, handling, and destruction of high-risk materials, *Control of Hazardous Materials in VA Research Laboratories,* was published November 20, 2002. It should be noted that this guidance directs that clinical laboratories follow this guidance as well. A draft handbook has already been posted on ORD's Web site. Following the publication of the handbook, ORD will evaluate the effectiveness of and compliance with the policy by using security assessments system-wide to address the OIG's findings. In addition, on September 17, 2002, the Deputy Under Secretary for Operations and Management and the Acting Deputy Under Secretary for Health jointly issued a memorandum advising all facilities with Biosafety Level (BSL) 3 laboratories of the Under Secretary for Health's directive that affected facilities conduct a security self-assessment of their BSL 3 laboratories using a specifically provided checklist by mid-October 2002. Sites that fail to meet standards in the checklist will be reinspected within 30 days. BSL 3 laboratories that fail the reinspection will suspend operations until they fulfill the specified security requirements. The memorandum also announced that ORD and the Director of Safety and Technical Services (10NB) will conduct periodic announced and unannounced inspections of BSL 3 facilities at least once per year, beginning in January 2003.

In response to the OIG's report, *Evaluation of VHA's Policies and Practices for Managing Violent and Potentially Violent Psychiatric Patients*, VHA considered a number of ways

to address the recommendation on patient flagging systems, none of which were fully responsive. Planning for an automated system that will implement the remaining open report recommendation began in August 2002 and is scheduled for completion in July 2003. A directive on the patient flagging system will be developed, and satellite training on the system will follow completion of the software.

2. Resource Allocation

In 1997, Congress required VA to address resource inequities nationwide. Public Law 104-204 mandated that VA develop a plan to improve the distribution of medical care resources and ensure that veterans had an equitable access to health care across the United States. As a result, VA developed the Veterans' Equitable Resource Allocation (VERA) system.

Prior to FY 1997, VA used three different resource allocation systems.[1] They were designed to improve certain functions of each preceding funding allocation system. VAMCs received and managed their own budgets, and annual incremental increases were based on prior year allocations. Funds allocated through each of these systems were based on historic funding imbalances, which perpetuated inequitable allocations of resources and unequal access to care. The inequities that resulted were caused by a shift in the veteran population demographics without an accompanying shift in resource allocations.

The VERA system is a capitation-based allocation methodology that moves funds among the VISNs based on patient workload. The allocation methodology provides incentives for achieving cost efficiencies and increased funding to serve more veterans. VISNs maintain responsibility for allocating resources among the facilities in their prescribed geographic areas. Over the last 5 years, allocations based on VERA have resulted in the shifting of significant amounts of resources to VISNs that were previously under-funded; however, resource allocation issues remain unresolved.

Current Status

In August 2001, the OIG issued a report titled *Audit of Availability of Healthcare Services in the Florida/Puerto Rico Veterans Integrated Service Network 8* (Report No. 99-00057-55). The report recommended that the VERA model include Priority 7 veterans (the majority of whom are currently excluded) so that the total number of veterans enrolled and treated is appropriately considered in funding decisions.

VHA is evaluating proposed changes to the FY 2003 VERA methodology to include Priority 7 veterans in the allocation methodology as the OIG and the General Accounting Office (GAO) recommended (*GAO Report - VA Health Care: Allocation Changes Would Better Align Resources with Workload* [GAO-02-338]). We note that VHA remains concerned with uncontrolled growth if Priority 7 veterans are included in the VERA allocation model.

VA's Program Response

On November 20, 2002, the Secretary announced an overhaul of the VERA methodology. The changes to VERA are taken from recommendations made by GAO and the RAND Corporation. The latest changes will allow VA to: (i) more accurately tie VA funding for networks to the complexity of care received by patients with per-patient funds ranging from about $263 to more than $60,000; (ii) provide more funding to networks for the most severely ill patients; (iii) eliminate the need for special mid-year funding supplements for networks by addressing the issues that previously led to such requests; and, (iv) contain and manage workload growth. In 2003, the changes will result in a minimum increase of 5 percent and a maximum increase of 12.6 percent for VISNs above the final 2002 VERA allocations. The Secretary decided not to include Priority 7 veterans in the VERA model as proposed by the OIG and GAO. Although the inclusion of nonservice-connected/noncomplex care Priority 7 veterans in the VERA Basic Vested Care category would be a step toward better aligning the VERA allocation model with VA's actual

[1] (A) prior to 1985 -- Incremental Funding, (B) 1984-1985 -- Resource Allocation Model, and (C) 1984-1997 -- Resource Planning and Management Model.

enrollment experience, including these veterans in the VERA model would create financial incentives to seek out more of these veterans instead of veterans with service-connected disabilities, those with incomes below the current income threshold, or special needs patients (e.g., the homeless), who comprise VA's core health care mission. VA experienced uncontrolled growth in the Priority 7 veterans when they were not included in the VERA model, and we do not want to encourage unmanageable growth by including them in the VERA model.

Allocation of resources is a zero sum game. Increased resources for Priority 7 veterans would come at the expense of veterans who are service-connected, poor, or who require specialized services. Allocation of resources to areas with a disproportionate percentage of Priority 7 veterans would come at the expense of veterans who live in areas with disproportionately higher numbers of service-connected and low-income veterans.

3. Compensation and Pension (C&P) Timeliness and Quality

For the past quarter century, VBA has struggled with timeliness and quality of claims processing; it continues to face significant problems. A large backlog of compensation claims continues to build as a result of an unacceptably long time to process the claims. As of July 30, 2002, VBA reported an inventory of more than 482,000 cases. In FY 2002, VBA reported that C&P rating-related actions took an average of 223 days to process.

Current Status

In December 1997, the OIG issued a report titled *Summary Report on VA Claims Processing Issues* (Report No. 8D2-B01-001) that identified opportunities for improving the timeliness and quality of claims processing and veterans' overall satisfaction with VA claims services. In our September and October 1998 reports titled *Audit of Data Integrity for Veterans Claims Processing Performance Measures Used for Reports Required by the Government Performance and Results Act* (Report No. 8R5-B01-147) and *Accuracy of Data Used to Measure Claims Processing Timeliness* (Report No. 9R5-B01-005), we reported that three key C&P timeliness measures lacked integrity and that actual timeliness was well above reported timeliness. The OIG closed these three reports after VBA actions. Recent Combined Assessment Program (CAP) reviews[2] found C&P claims processing was untimely at all 10 facilities where we reviewed timeliness; we did not review data quality.

In October 2001, the Claims Processing Task Force issued a report to the VA Secretary recommending measures and actions to increase the efficiency and productivity of VBA operations, shrink the backlog of claims, reduce the time it takes to decide a claim, and improve the validity and acceptability of decisions. The task force report made 34 recommendations (20 short-term and 14 medium-term). VBA has defined 62 actions they can take to fully accomplish the 34 recommendations. VBA has pursued implementation of the recommendations and reports 10 of the action items are completed.

VA's Program Response

Since the Claims Processing Task Force Report was released to the VA Secretary in October 2001, significant improvement has been shown in the area of claims processing timeliness. The backlog of the total number of claims and claims pending over 6 months continues to diminish as VBA implements the recommendations outlined in the report. VBA's accomplishments in 2002 are outlined on the following page.

[2] Through this program, auditors, investigators, and health care inspectors collaborate to assess key operations and programs at VA health care systems and VA regional offices on a cyclical basis.

	Peak	As of Sept 30
• Total claims pending	601,237	465,950
• Rating cases pending	432,659	344,183
• Total claims pending over 6 months	230,796	139,603
• Rating cases pending over 6 months	204,475	120,900
• Non-rating cases pending over 6 months	23,147	13,556
• Average days to complete for rating cases	233.5	208.8
• Average days pending for rating cases	202.7	174.2
• Average days to complete non-rating cases	76.5	53.6
• Average days pending for non-rating cases	126	95.7

VBA recognizes that continued improvement in the area of claims processing needs to be shown. As a result, the Claims Processing Improvement Task Team developed implementation strategies to move from a case management approach to a work-processing model based on specialized claims processing teams. All offices began operating under this new model on September 30, 2002. Hiring and training is expected to be completed in 2003. VBA believes the new claims processing model will significantly improve claims processing through uniformity in decision-making, specialization, and standardization in regional office organization structure.

4. Erroneous and Improper Payments

OIG audits and investigations found that improper payments are a significant problem in the Department. Improper payments have been attributed to poor oversight, monitoring, and inadequate internal controls. As a result, improper payments have occurred because of payments to ineligible veteran beneficiaries, fraud, and other abuses. VA has not disclosed the monetary value of improper payments on its financial statements.

The risk of improper payments is high given the significant volume of transactions processed through VA systems and the complex criteria often used to compute veterans' benefits payments. Without systematic measurement of the extent of improper payments, VA will not be in a position to target mitigation strategies.

Current Status

In FY 2002, the OIG completed a review of all one-time C&P payments valued at $25,000 or more, made since 1995, to determine if the payments were valid. The VA Secretary requested this review in September 2001, following the discovery that an employee at the VARO in Atlanta, GA, had bypassed controls and generated fraudulent payments. We determined that most one-time payments reviewed were valid; however, we found there were unacceptable, high rates of noncompliance with internal control requirements related to one-time payments and C&P claims processing. The OIG is investigating 316 cases associated with veterans' claims files that could not be located during our review.

VA needs to develop and implement an effective method of identifying inappropriate benefit payments. Recent OIG audits found that the appropriateness of VBA payments has not been adequately addressed. VA needs to report "Improper Payments" dollar figures on four of its programs in the Department's budget submission in accordance with the OMB Circular No. A-11, Section 57 reporting requirements. The four programs include Compensation, Dependency and Indemnity Compensation, Pension, and Insurance.

In late FY 2002, the OIG began work to evaluate the validity and reasonableness of current and former VBA employees' compensation ratings and awards. We are assessing whether VBA has adequate controls to prevent fraud and ensure that favoritism does not influence the ratings and awards to VBA employees.

We also have issued a report addressing the accuracy of reported unreimbursed medical expenses of pensioners. Results showed that

submissions from pensioners are significantly impacting the level of their benefits. VBA's processing of these submissions is not being handled effectively, resulting in processing errors and program fraud, with benefit overpayments of about $125 million and underpayments totaling as much as $20 million annually.

We continue to focus our efforts on leveraging audits and investigations to produce systemic improvements and procedural reforms that reduce erroneous and improper payments in VA and limit future opportunities for fraud and other abuses to occur. Below, we have highlighted some of our major audits and investigations where significant improper payments were identified.

VA's Program Response

The Department of Veterans Affairs Financial Services Center (FSC) uses monthly performance measures to review the accuracy and timeliness of various payments processed through the Financial Management System (FMS). The FSC systematically reviews daily payments to identify potential duplicate payments for further analysis and validation. The GAO cited our audit recovery process in their Executive Guide to Managing Improper Payment Report (GAO-02-69G) as a "Best Practice."

Description	Amount Collected
Duplicate Payments	$2.4 Million
Outstanding Credits from Vendor Statements	$1.0 Million
Duplicate Payments Cancelled Before Treasury Issuance*	$1.6 Million
Total	$5.0 Million

*Duplicate payments cancelled prior to Treasury issuance represent a cost avoidance for VA by preventing duplicate vendor payments and the resulting collection efforts.

Through August 2002, the FSC collected $3.4 million in improper payments (both billable and non-billable) and prevented an additional $1.6 million in potential improper payments. The FSC continues to pursue outstanding balances.

Recently, the FSC analyzed the outstanding duplicate payment backlog and solicited the assistance of the Chief Financial Officers of VHA and VBA in validating and collecting old, outstanding duplicate payments. As a result, in August 2002, the FSC collected $547,000 (of the combined billable and non-billable collections) versus the prior 3-month average of $413,000. Also, continuous process improvements enabled the FSC to reduce its duplicate payments by an average of 15 percent per month since March 2002.

In addition to the recovery audit effort and the identification of potential duplicate payments, the FSC created a new FMS training course that specifically addresses FSC-made payments. This course targets risk areas identified by quarterly performance measure reviews, special analyses, and other FSC-specific transactions.

Currently, the FSC reviews payments within a 90-day period. During FY 2003, they expect to increase the review period to approximately 1 year to expand their oversight capability. The FSC will also expand its audit recovery reviews to include purchase card payments.

VBA has consolidated pension claims processing activities into three pension maintenance centers. Key goals of the consolidation include enhanced performance of program integrity as well as consistency and improved quality in administration of the pension program. One of the performance measures for the pension centers will be their program integrity efforts. Processing claims for unreimbursed medical expenses is a vital part of this effort.

4.A. OIG Issue - Fraudulent One-Time Retroactive Benefits Payments

Criminal charges of conspiracy, theft of Government property, and a violation of

principles against the United States were filed on 12 individuals involved in a major theft against VA. The charges also seek forfeiture of certain properties identified as purchased by the subjects with illegally obtained VA money. An ongoing investigation has disclosed that a VA employee accessed and falsified numerous VBA files to generate hundreds of fraudulent benefits payments under the accounts of veterans who had died and had no beneficiaries. Subsequently, large retroactive benefits checks were disbursed or electronically deposited into accounts belonging to accomplices. The investigation disclosed that individuals defrauded VA of approximately $11.2 million between 1993 and August 2001.

VA's Program Response

Regional office directors are now required to verify the propriety of all retroactive Compensation and Pension payments of $25,000 or more. They must (1) review the claims folder, (2) verify there is a rating decision in the folder with an award printout or other documentation that supports a retroactive payment of $25,000 or greater, (3) verify the payment was properly issued to the veteran or beneficiary, and (4) ensure there is evidence to justify the award action. VBA's Office of Performance Analysis and Integrity monitors compliance weekly; to date, no additional instances of fraud have been found. In addition, the C&P Service's program support staff reviews regional office compliance with the $25,000 certification process as part of their station site visit process. This review process also includes veterans receiving very large monthly compensation payments and veterans over 100 years old.

4.b. OIG Issue - Philippines Benefit Review

During April and May 2002, the OIG and VARO Manila staff worked together on an international review at the request of the Director, VARO Manila to identify and suppress erroneous benefit payments and stop "claims fixers." This project found $2.5 million in overpayments and identified $21 million in 5-year cost savings. This project has developed several criminal investigations that will continue to be pursued during the next fiscal year. As a result of the success of this project, the OIG intends to expand international reviews.

VA's Program Response

In December 2002, the OIG will send VBA a summary of the findings from the Philippines Benefit Review, along with suggestions to reduce the number of future deceased payee and false claims cases. Upon receipt of this summary, VBA will take appropriate steps.

4.c. OIG Issue - Death Match Project

The OIG death match project is being conducted to identify individuals who may be defrauding VA by receiving VA benefits intended for beneficiaries who have passed away. Investigations to date have resulted in the actual recovery of $5.4 million and a 5-year projected cost savings to VA of $16 million. There have been 42 arrests on these cases with several additional cases awaiting judicial action. This project will be updated on an annual basis with new information. The death match project continues to be a priority project of the OIG.

VA's Program Response

A new Death Match file is released to VA regional offices every month. The monthly file averages approximately 5,000 new cases. Regional Offices submit annotated copies of Death Match listings for all cases that are 4 or more months old to the Compensation and Pension Service. This process has been in place for several years.

4.d. OIG Issue - Fugitive Felon Program

On December 27, 2001, Public Law 107-103 was enacted to prohibit veterans who are fugitive felons, or their dependents, from receiving specified veterans benefits. In addition, the law requires the Secretary to furnish law enforcement personnel, upon request, the most current address of a veteran who is determined to be a fugitive felon. A pilot research study was conducted, prior to enactment of the law, with the U.S. Marshals Service (USMS) and the States of California (CA) and Tennessee. The study produced 5,874 matches between fugitive

felon warrants and beneficiaries in various VA databases. There was approximately $20 million in total benefit value associated with these fugitive matches. A memorandum of understanding (MOU) was signed with USMS in April 2002, and an agreement with the State of California was signed in July 2002, to electronically match their fugitive felon warrant files with various VA databases. We expect an MOU to be signed in December 2002 with the National Crime Information Center (NCIC). Agreements with additional states will be negotiated over the next 2 years. Based on the pilot study and the first match with USMS, the OIG anticipates that between 1 and 2 percent of all the fugitive felony warrants submitted will involve veteran beneficiaries. Savings in FY 2003 are expected to be in the millions of dollars.

VA's Program Response

The OIG is responsible for the front end of the fugitive felon program. At any given time, more than 100,000 individuals are on a fugitive felon list maintained by the Federal government and/or State and local law enforcement agencies. Gaining access to these listings requires an MOU between the VA OIG and the owner of the listing. The OIG has conducted matches of fugitive felon data received from the USMS and CA against eight VA files. The OIG referred 70 VA beneficiaries identified as fugitive felons to the USMS. They are currently preparing the data referral for CA. The OIG has also developed an Oracle database application to track referrals to law enforcement as well as VBA and VHA. The OIG is working to get an MOU with the NCIC, a component of the Department of Justice. Currently there are in excess of 575,000 felony warrants in the NCIC system.

4.e. OIG Issue - Payments to Incarcerated Veterans

In February 1999, the OIG published a report titled *Evaluation of Benefit Payments to Incarcerated Veterans* (Report No. 9R3-B01-031). The review found that VBA officials did not implement a systematic approach to identify incarcerated veterans and adjust their benefits as required by Public Law 96-385. The evaluation included a review of 527 veterans randomly sampled from the population of veterans incarcerated in 6 states. Results showed that VAROs had not adjusted benefits in over 72 percent of the cases requiring adjustments, resulting in overpayments totaling $2 million. Projecting the sample results nationwide, we estimated that about 13,700 incarcerated veterans had been, or will be, overpaid about $100 million. VBA recently implemented the final open recommendations in the report by forwarding instructions to the VAROs to review state and local prison matches.

VA's Program Response

An agreement was reached with the Social Security Administration (SSA) that allows VA to use the State Verification and Exchange System (SVES) to identify claimants incarcerated in State and local facilities. The initial output of that agreement produced over 44,000 beneficiaries in the first 25 digits of our current awards processing payment system, the Benefits Delivery Network (BDN). Programming has been rewritten and we are now processing both Bureau of Prisons match and SSA prison match cases on a monthly basis. The first output was produced on June 17, 2002, for terminal digits 00-24; the second run was dated July 8, 2002, for terminal digits 25-49; and a third file was run on August 17, 2002, for terminal digits 50-74. The total number of generated hits was over 12,000.

4.f. OIG Issue - Benefit Overpayments Due to Unreported Beneficiary Income

Our November 2000 report titled *Audit of VBA's Income Verification Match Results* (Report No. 99-00054-1) found that opportunities exist for VBA to: (i) significantly increase the efficiency, effectiveness, and amount of potential overpayments that are recovered; (ii) better ensure program integrity and identification of program fraud; and (iii) improve delivery of services to beneficiaries.

The audit found that VA's beneficiary income verification process with the Internal Revenue Service resulted in a large number of unresolved cases. The monetary impact of these potentially

erroneous payments totaled $806 million. Of this amount, we estimated potential overpayments of $773 million associated with benefit claims that contained fraud indicators such as fictitious Social Security numbers or other inaccurate key data elements. The remaining $33 million was related to inappropriate waiver decisions, failure to establish accounts receivable, and other process inefficiencies. We also estimated that $300 million in beneficiary overpayments involving potential fraud had not been referred to the OIG for investigation.

VBA has implemented seven of eight recommendations from the November 2000 OIG report; however, the recommendation to complete necessary data validation of beneficiary identifier information contained in C&P master records to reduce the number of unmatched records with the Social Security Administration remains unimplemented. This recommendation was a repeat recommendation from our 1990 report.

VA's Program Response

In 2001, VBA began the process of consolidating the pension maintenance activities from all 57 ROs to 3 sites in Philadelphia, Milwaukee, and St. Paul. The impetus for the consolidation was the deterioration of service and quality in administering the complex, labor-intensive pension programs. Through this consolidation, VBA will develop a specialized expertise in pension maintenance processing, which will lead to greater uniformity in decision-making and more efficient processes.

In 2002, the Pension Maintenance Centers assumed responsibility for Income Verification Match (IVM) processing. The IVM is performed by running VA records against files from the Social Security Administration (SSA) containing earned income data and files from the Internal Revenue Service (IRS) containing unearned income data. The SSA and IRS matches were conducted in May and August 2002, respectively, and identified more than 30,000 cases, which are now being reviewed and verified. This process will continue to be performed on an annual basis.

VBA is actively working to address the remaining open recommendation -- the validation of beneficiary identifier information contained in the C&P master record with SSA data. In July 2002, VBA conducted an initial run of the social security number (SSN) verification process. Upon analyzing the results, the C&P Service determined that additional programming changes were required to clean up the unverified SSN listing and to add spouses to the verification process. The installation of the new process is expected by the end of December 2002.

4.G. OIG Issue - Disability Compensation Benefits for Active Military Reservists

In May 1997, the OIG conducted a review to determine whether VBA procedures ensure that disability compensation benefits paid to active military reservists are offset from training and drill pay as required by law. The OIG report titled *Review of VBA's Procedures to Prevent Dual Compensation* (Report No. 7R1-B01-089) reported that VBA had not offset VA disability compensation to 90 percent of the sampled active military reservists receiving military reserve pay. We estimated that dual compensation payments of $21 million were made between FY 1993 and 1995. If the procedures were not corrected, we estimated $8 million in annual dual compensation payments would continue to be made. Dual payments occurred because procedures established between VA and the Department of Defense (DoD) were not effective or were not fully implemented. In September 2002, VBA implemented the final recommendation by forwarding drill pay waiver forms to all reservists/guardsmen who received both drill pay and VA benefits during the fiscal year.

VA's Program Response

VA and DoD have worked to correct procedures and processes to ensure dual compensation benefits are properly offset. During September 2002, VBA released approximately 28,000 VA Forms 21-8951, "Notice of Waiver of VA Compensation or Pension to Receive Military Pay and Allowances" for FY 2001. The forms have been mailed to veterans, asking them to return theirs to the RO of

jurisdiction. As these waiver forms are received at the ROs, benefits will be offset accordingly.

4.h. OIG Issue - Benefit Overpayment Risks Due to Internal Control Weaknesses

In FY 1999, the Under Secretary for Benefits asked for OIG assistance to help identify internal control weaknesses that might facilitate or contribute to fraud in VBA's C&P program. The request followed the discovery that three VBA employees had embezzled over $1 million by exploiting internal control weaknesses in the C&P program.

To test the existence of the control weaknesses identified in the vulnerability assessment, we conducted an audit at the VARO in St. Petersburg, FL. That VARO was selected for review because it was one of the Department's largest VAROs, accounting for 6 percent of C&P workload, and was the location where two of three known frauds took place. The July 2000 report titled *Audit of the C&P Program's Internal Controls at VARO St. Petersburg, FL* (Report No. 99-00169-97) confirmed that 16 of 18 categories of vulnerability reported in our vulnerability assessment were present at the VARO. VBA agreed to address the 18 internal control weaknesses identified in the vulnerability assessment and the 15 multi-part recommendations identified in the St. Petersburg audit. Implementation action on these recommendations is currently in progress.

VA's Program Response

The OIG audit of the C&P Program's internal controls at the St. Petersburg Regional Office identified 15 multi-part recommendations comprised of 26 actionable items. To date, fifteen of the 26 action items have been closed. Four of the open OIG recommendations are contingent upon full deployment of our new award processing system. The final stage of this deployment is scheduled to be completed by the end of the fourth quarter of FY 2004. Two other recommendations require no additional VBA action and will be closed by the OIG following Combined Assessment Program (CAP) reviews. VBA is currently working toward implementing the remaining five recommendations outlined in the audit.

5. Government Performance and Results Act (GPRA) - Data Validity

Successful implementation of GPRA, including performance-based budgeting, requires that information be accurate and complete. VA has made progress implementing GPRA, but additional improvement is needed to ensure that stakeholders have useful and accurate performance data. Management officials continue to refine performance measures and procedures for compiling data. Performance data are receiving greater scrutiny within the Department, and procedures are being developed to enhance data validation. However, we continue to find significant problems with data input, and Departmentwide weaknesses in information systems security limit our confidence in the quality of data output.

Current Status

At the request of the Assistant Secretary for Policy and Planning, we initiated a series of audits to assess the quality of data used to compute the Department's key performance measures. During the period FY 1998 through FY 2001, OIG reported on the following six performance measures:

- Average days to complete original disability compensation claims – at the time of the audit, 34 percent of the records reviewed contained inaccurate or misleading data.
- Average days to complete original disability pension claims – the audit found 32 percent of the records reviewed contained inaccurate or misleading data.
- Average days to complete reopened compensation claims – The number of reopened claims was in ated by 18 percent. Of the records reviewed in the audit, 53 percent contained inaccurate or misleading data.
- Percent of the veteran population served by the existence of a burial option within a reasonable distance of place of residence –

VA could not recreate population projections used to calculate this measurement because essential data no longer existed.

- Foreclosure avoidance through servicing ratio – The OIG was unable to attest to the accuracy of the reported ratio because VBA did not maintain necessary documentation at that time.
- Unique patients – VHA overstated the number of unique patients by 6 percent.

VBA, VHA, and NCA have taken action to correct the deficiencies we identified and have implemented all the recommendations in the OIG reports related to these deficiencies. For example, to improve the data used to measure claims processing timeliness, VBA clarified related policies and procedures, added a data integrity segment to the training package for veterans service representatives, began collecting and analyzing transaction data to identify questionable transactions, and resumed site visits to regional offices to monitor compliance.

The Office of the Assistant Secretary for Management identified the following management challenges to the successful implementation of GPRA: (i) better alignment of budget accounts with GPRA programs; (ii) improvement of financial management systems report structure and timeliness; and (iii) improvement of cross-cutting activities between VA and the Department of Defense.

Audits of three key performance measures -- VBA's vocational rehabilitation and employment program rehabilitation rate, VHA's chronic disease care index, and VHA's prevention index -- are in process. Draft audit results indicate the OIG will not be able to attest to the accuracy of the rehabilitation rate because personnel in VBA regional offices inappropriately classified about 16 percent of the veterans in the audit sample as rehabilitated. Results of the audit assessing the chronic disease care index and prevention index measures are not yet available.

VA's Program Response

Data reliability, accuracy, and consistency have been targeted focuses of VHA for the past several years. The principles of data quality are integral to their efforts to provide excellence in health care. VHA's Data Consortium addresses organizational issues and basic data quality assumptions, working collaboratively to improve information reliability and customer access for the purposes of quality measurement, planning, policy analyses, and financial management. The ongoing initiatives and strategies address data quality infrastructure, training and education, personnel, policy guidance, and data systems.

VHA implemented all of the recommendations identified regarding over-reporting the number of unique patients by 6 percent, and is waiting for the release of the OIG's audit of the chronic disease care and prevention indexes.

To better align budget accounts with GPRA programs, VBA has aligned the FY 2004 budget submission by benefit programs (e.g., compensation and pension) and completed separate narratives for each program. In regard to crosscutting activities between VA and DoD, VBA has entered into a number of interagency agreements with DoD to improve and expedite the claims process. One such agreement will link the Personnel Information Exchange System with the Center for Unit Records Research to obtain information in support of claims for Post Traumatic Stress Disorder. Additionally, we have entered into agreements to expand the Benefits Delivery at Discharge program to include the development of one VA/DoD physical examination protocol to satisfy both VA and DoD requirements.

The OIG originally issued this finding: "OIG was unable to attest to the accuracy of the reported ratio because VBA did not maintain necessary documentation at that time," in its report entitled, "*Accuracy of Data Used to Compute the Foreclosure Avoidance Through Servicing (FATS) Ratio"* on November 16, 2000. An audit was conducted between April 1999 and July 2000 and focused primarily on the old Liquidation Claims System, which did not retain servicing notes longer than 60 days following the reinstatement (cure) of a delinquent loan. Thus,

the OIG was able to verify only a portion of the successful VA interventions included in the FATS ratio during that period because some cases did not involve the establishment of paper files. Thus, the OIG had neither paper nor electronic files to review. VBA now maintains all data needed for the OIG to attest to the accuracy of current FATS ratios. The Loan Service and Claims (LS&C) system, which was rolled out in August 1999, retains servicing notes on cases indefinitely. For all cases handled in LS&C since August 1999, electronic records are maintained and are now available for review.

In response to the OIG's draft audit report findings and recommendations, Vocational Rehabilitation & Employment (VR&E) made plans to take the following actions in 2003:

- The number of cases for review in the new Quality Assurance (QA) process will be increased.
- The new QA process will require review of cases at both the local and headquarters levels.
- The VR&E field survey staff will visit 12 stations within the fiscal year.
- Cases declared rehabilitated and discontinued will require approval and signature of the VR&E manager.

6. Security of Systems and Data

VA faces significant challenges in addressing Federal information security program requirements and establishing a comprehensive integrated VA security program. Information security is critical to ensure the confidentiality, integrity, and availability of VA data and the assets required to support the delivery of health care and benefits to the Nation's veterans. VA is highly dependent on automated information systems in the delivery of these services. However, the lack of management oversight at all levels has contributed to inefficient practices and to weaknesses in safeguarding electronic information and physical security of assets.

Current Status

Previous OIG audit reports have identified weaknesses in information security throughout VA. With passage of the Government Information Security Reform Act (GISRA) as part of the FY 2000 Defense Authorization bill, the OIG is required to complete an independent assessment of VA's compliance with the Act. Limited information developed by VA on existing information security vulnerabilities precluded establishment of a baseline on the adequacy of VA's information security. Therefore, the OIG performed vulnerability assessments and penetration tests of selected segments of the Department's electronic network of operations to identify vulnerabilities that place sensitive data at risk of unauthorized disclosure and use. Our October 2001 audit, titled *Audit of the Department of Veterans Affairs Information Security Program* (Report No. 00-02797-1), reported that information security weaknesses exist and, as a result, require the continuing designation of information security as a Department material weakness under the Federal Managers' Financial Integrity Act.

Our FY 2002 GISRA audit found that VA systems continue to be vulnerable to unauthorized access and misuse of sensitive automated information and data. The Department started efforts to correct these weaknesses and work toward compliance with the GISRA requirements.

Key accomplishments by the Department include: (i) establishment of an enterprise-wide security plan, policies, procedures, and guidelines as required by GISRA; (ii) implementation of a Departmentwide anti-virus protection application; (iii) appointment of information security officers; (iv) establishment of priorities for remediation of key security weakness areas; and (v) installation of sensor devices at selected sites to enhance protection of network resources from external attacks.

Results of the 2002 GISRA audit identified significant information security vulnerabilities that continue to place the Department at risk of: (i) denial of service attacks on mission-critical systems; (ii) disruption of mission-critical systems;

(iii) unauthorized access to and disclosure of data subject to Privacy Act protection and sensitive financial data; and (iv) fraudulent payment of benefits.

The audit identified the following key issues:

- VA is not making sufficient progress to correct information security vulnerabilities that continue to place the Department's programs and sensitive data at risk to potential destruction, manipulation, and inappropriate disclosure. VA requires a better coordinated and focused security program to address its significant information security weaknesses.
- Many information system security weaknesses reported in our 2001 GISRA audit remain unresolved, and additional security weaknesses were identified. Milestones established for eliminating key security weakness areas will take too long to complete, and will prevent the Department from effectively strengthening its overall security posture in the near-term. As a result, VA's systems and data will continue to be at risk and its security program will not be in compliance with GISRA.
- Internal penetration tests verified that VA systems could be exploited to gain access to sensitive veteran benefit and health care information.

VA's Program Response

In a memorandum dated August 6, 2002, the Secretary directed that all IT personnel and resources be centralized under the Office of Information and Technology. This action is targeted toward countering the Department's historical legacy of diverse and inconsistent IT management practices, as well as an inherent cultural resistance to headquarters-level programmatic direction. The Secretary mandated that the VA Chief Information Officer provide a conceptual framework of this new command structure, with an associated implementation schedule. The plan was submitted to the Secretary on November 1, 2002. This consolidation will reinvigorate the Department's progress toward developing an enterprise architecture and ensuring the inclusion of a dynamic security baseline in that architecture. Additionally, it will eliminate redundancies, leverage existing resources to preclude duplicative efforts, and establish a coordinated and focused security program to address VA's significant information security vulnerabilities on an expedient basis, while at the same time ensuring appropriate attention to component-specific security issues.

VA, while not in complete compliance with GISRA, appropriately identified IT security control deficiencies in both the 2001 and 2002 GISRA self-assessment surveys, initiated a process to correct those deficiencies on a priority basis, and has instituted an effective agency-wide security program planning and management capability in the Office of Cyber Security.

However, analysis of information contained in the Department's GISRA database indicates that some self-reported progress may be overly optimistic or may not accurately reflect the current security status of some IT systems. Therefore, during FY 2003, the Department will establish an independent compliance capability to validate the accuracy of self-reported information in the database, as well as conduct external and internal penetration testing to ensure that previously identified vulnerabilities have been adequately remediated. These processes will ensure the integrity of GISRA-related information as the Department moves rapidly forward in efforts to improve its overall IT security posture.

The Enterprise Cyber Security Infrastructure Project (ECSIP) merges VA's actions to implement a Departmentwide intrusion detection system (IDS) and, concurrently, upgrade Internet Gateway Security. This project, which was approved by the Department's Strategic Management Council in February 2002, coincides with VA's telecommunications transition to a performance-based network. A plan has been developed to systematically collapse the over 200 existing Internet gateways in VA into a more manageable number and efficient structure. Concurrent with this effort, Departmentwide IDS capability will be incrementally deployed on a strategic basis to provide significantly increased security protections

for these gateways. The IDS effort includes establishment of two Security Operations Centers to provide real-time analytical incident support, as well as information-sharing capabilities with appropriate public and private organizations regarding emerging threats and vulnerabilities. Design and implementation of this standardized architecture and configuration will better protect VA's internal critical information repositories from attack. This project is an essential component of VA's approach to implementing a secure enterprise architecture.

7. Federal Financial Management Improvement Act (FFMIA) and VA's Consolidated Financial Statements (CFS)

Since FY 1999, VA has achieved unqualified CFS audit opinions. However, continuing material weaknesses, such as information technology security controls and noncompliance with the Federal financial management system requirements, were identified. Corrective actions needed to address noncompliance with financial system requirements are expected to take several years to complete. There were four additional material weaknesses reported in FY 2001 on loan guaranty application systems, reliance on independent specialists, management legal representations, and management ownership of financial data. These weaknesses are addressed below.

7.A. OIG Issue - Integrated Financial Management System Material Weakness

The material weakness concerning the Department's financial management systems underscores the importance of acquiring and implementing a replacement integrated core financial management system. Achieving the success of an unqualified CFS opinion currently requires a number of manual compilations and extraneous processes that the financial management system should perform. These processes require extraordinary administrative efforts by the program, financial management, and audit staffs. As a result, the risk of materially misstating financial information is high. Efforts are needed to ensure adequate accountability, and reliable, useful, and timely information needs to be available to help Department officials make well-informed decisions and judgments.

The February 2002 OIG CFS report noted continuing difficulties related to the preparation, processing, and analysis of financial information needed to support the efficient and effective preparation of VA's CFS. Significant efforts are made at the component and consolidated level to assemble, compile, and review necessary financial information for annual reporting requirements; however, VA has not yet completed its transition to a fully integrated financial management system. Examples include: (i) general ledgers for some smaller funds were maintained outside the existing core financial management system; (ii) unreconciled differences between the general ledgers and the property management system subsidiary ledger existed; and (iii) a significant number of manual adjustments were used during the year-end closing process.

VA's Program Response

VA has remediation plans in place to address the FFMIA weaknesses as well as additional weaknesses identified in the annual financial statements audit. Progress in implementing corrective actions is being monitored by top management on a monthly basis. We expect to resolve three of the six weaknesses before the end of this calendar year. These three weaknesses include Reliance on Independent Specialists, Management Legal Representations, and Management Ownership of Financial Data. Corrective actions for the remaining three weaknesses (Integrated Financial Management System; Loan Guaranty Application System; and Information Technology Security Controls) are being implemented, but the completion of these actions is long–term, requiring significant staff and resources to complete.

CoreFLS staff is engaged in ongoing meetings with OIG staff responsible for the audit of the Department's consolidated financial statements

as well as meeting with OIG staff responsible for the audit of VBA systems. The purpose of these meetings is to document how CoreFLS will contribute to correcting many of the findings in the OIG audit report and management letter listing Departmental reportable conditions and additional observations. The outcome of these meetings with OIG staff will produce a CoreFLS document that details the contributions CoreFLS will make to resolve OIG concerns. The CoreFLS document, "Resolving OIG Concerns," will be completed in November 2002. For each reportable condition and management observation, the role CoreFLS plays in mitigating the concern is being defined. CoreFLS alone may not remedy an OIG reportable condition or management observation, and some reportable conditions and management observations are clearly outside the scope of CoreFLS. This document will include the degree to which CoreFLS will mitigate each OIG concern that is in scope. For all OIG concerns that are in scope, the gains to be realized from CoreFLS will not be evident until after full system implementation in 2006.

Information Technology Security Controls

Since 1998, inadequate implementation of appropriate controls has resulted in information system security being identified as a material weakness in VA's annual FFMIA report. To remove this designation, VA has used the GISRA process to prioritize and remediate those deficiencies that will have the most significant impact on the Department's overall security posture in the near term. Performance in this area is measured through compliance with Federal Information System Controls Audit Manual (FISCAM) control areas, which indicates that VA has increased compliance with FISCAM objectives by 25 percent this year. Although the material weakness still exists for FY 2002, additional activities targeted toward remediation of VA's priority weakness areas are anticipated to remove this designation by FY 2004, concurrent with full implementation of the ECSIP.

The ECSIP merges VA's actions to implement a Departmentwide IDS capability (priority one) and, concurrently, upgrade IT security controls on Internet gateways (priority six). During its initial phase, a plan will be developed to systematically collapse the over 200 existing Internet Gateways in VA into a more manageable number and efficient structure. Concurrent with this effort, Departmentwide IDS capability will be incrementally deployed on a strategic basis to provide significantly increased security protections for these gateways. Design and implementation of this standardized architecture and configuration will better protect VA's information systems and internal critical information repositories from attack on a cost-effective basis.

7.b. OIG Issue - Loan Guaranty Application System Material Weakness

The FY 2001 audit identified material control weaknesses in critical loan guaranty system applications security and process controls due to a lack of accountability and definition of responsibility for implementing consistent security administration standards, and the lack of appropriate reconciliation processes and procedures. These weaknesses increase the risk of inappropriate system access, unauthorized or erroneous data transfer, and modification of production programs and data. This results in unreliable loan and property information being input into VA's core financial management system. Additionally, the lack of appropriate reconciliation of loan guaranty data among systems does not permit VBA the ability to detect unauthorized or erroneous data. Such weaknesses include:

- Unneeded access to common security administration manager functions; these control access to automated loan production system/ loan servicing and claims system functions/ data.
- Lack of accountability and responsibility for security administration and oversight of user access to the property management system and the guaranty/insured loan system.
- Lack of clearly defined responsibility for monitoring powerful user activities and

transactions within the loan guaranty system applications.

- Inadequate business continuity planning and testing for systems infrastructure supporting the loan guaranty system.
- Inconsistent application development and change management standards and compliance with established standards for application changes, testing, acceptance, and quality assurance.

VA's Program Response

The Office of the VA Deputy CIO for Benefits has lead reporting responsibilities for this material weakness. The Office of Information Management (OIM) and Loan Guaranty (LGY) have drafted a Management Accountability and Control Remediation Plan that has identified the following tasks for corrective action:

- Limit access to the Common Security Administration Manager System to three security managers (i.e., Common Security System team).
- Assign accountability and responsibility for security administration and oversight of access to the Property Management System and the Guaranteed and Insured Loan System.
- Establish policies and procedures for oversight of loan guaranty application systems.
- Establish and implement a development activity checklist identifying all components of the life cycle, responsibilities, and appropriate references for all application development.
- Establish and implement procedures for automated testing scripts.
- Define disaster recovery requirements for LGY.
- Develop LGY disaster recovery plan to include IBM, UNIX, and Internet/Intranet platforms.
- Pilot test and refine LGY recovery procedures.
- Incorporate LGY disaster recovery into the VA enterprise disaster planning and testing.

These corrective actions have varying start and completion dates. The earliest start date was March 2002, and the final completion date for disaster recovery tasks is February 2004. This plan is updated on a monthly basis regarding the current status of the OIM and LGY tasks.

7.c. OIG Issue - Reliance on Independent Specialists Material Weakness

VA relies on the use of actuarial consultants and other specialists for various financial statement assertions including compensation, pension, and burial liabilities; liabilities for loan guarantees; medical malpractice; and other liabilities. There were a number of instances during the FY 2001 audit that questioned the effectiveness of controls over outside actuarial and expert calculations. In FY 2002, the Office of the Actuary began reviewing the actuarial studies and providing results to management.

VA's Program Response

The Office of Policy and Planning has agreed to take on the following tasks identified by VA's auditor for corrective action:

- Provide independent verification of the work provided by specialists for the financial statements.
- Conduct experience studies to test management's assumptions used in various estimates.
- Conduct actuarial audits and independent recalculations to validate the models used and their application.

7.d. OIG Issue - Management Legal Representations Material Weakness

Management did not provide an adequate legal representation on pending litigation and contingent liabilities. The inadequate responses to support management's assertions on contingencies in the financial statements introduce the risk that material claims will not be properly reported and disclosed. During FY 2002, management and the auditors held further discussions with the General

Counsel on what information is needed in the legal representation.

VA's Program Response

The Office of General Counsel (OGC) provided the OIG an interim legal representation letter in September 2002, which is responsive to the requirement.

7.e. OIG Issue - Management Ownership of Financial Data Material Weakness

During the FY 2001 audit, VBA management in the compensation and pension and loan guaranty business lines provided insufficient review of accounting data and transactions. Management did not review the data prior to submission to the auditor nor provide information timely. During FY 2002, VBA management established an audit liaison function responsible for reviewing information prior to submission to the auditor to determine if amounts were accurate.

VA's Program Response

VBA management established a dedicated liaison responsible for clarifying and tracking all data requests and submissions to ensure accurate and timely data submissions. Data requests and response submissions are reviewed and discussed to ensure accuracy and a clear understanding by both parties. The VBA CFO has reemphasized the importance of timeliness and accuracy with the field stations as well as the business lines. Meetings are held regularly with the auditors at all levels to maintain clear lines of communication.

8. Debt Management

Debts owed to VA result from home loan guaranties; direct home loans; life insurance loans; medical care cost fund receivables; and compensation, pension, and educational benefits overpayments. As of June 2002, debts owed to VA totaled over $3.3 billion, of which active vendee loans comprise about 57 percent. Over the last 4 years, the OIG has issued reports addressing many facets of the Department's debt management activities. We reported that the Department should: (i) be more aggressive in collecting debts; (ii) improve debt avoidance practices; (iii) streamline and enhance credit management and debt establishment procedures; and (iv) improve the quality and uniformity of debt waiver decisions. VA has addressed many of the concerns reported over the last few years. However, our most recent audits continue to identify areas where debt management could be improved.

Current Status

The Department has reported performing considerable work in the area of debt referral to the Department of the Treasury. VA has reported it met or exceeded the Department of the Treasury goals for debt referral in 2002.

The OIG report titled *Evaluation of VHA's Income Verification Match Program* (Report No. 9R1-G01-054) issued in March 1999, found that VHA could increase opportunities to enhance MCCF collections by $14 million, and put resources valued at $4 million to better use, by requiring VISN directors to establish performance monitors for means–testing activities as well as billing and collection of program referrals. Additionally, to further ensure these monetary benefits are achieved, VHA management needed to implement previous recommendations, and the VHA Chief Information Officer needed to increase oversight of the Health Eligibility Center activities. VHA also needed to expedite action to centralize means testing activities at the Health Eligibility Center. VHA has not implemented 7 of 13 recommendations from this March 1999 report. Additional management attention is needed to ensure improvements in debt management occur.

In February 2002, we issued a report titled *Audit of the MCCF Program* (Report No. 01-00046-65) that found VHA could enhance MCCF revenues by requiring VISN and VA medical facility directors to better manage MCCF program activities. Many problems identified in FY 1998 are continuing to hinder VHA's ability to maximize collections. From FY 1997

through FY 2001, MCCF collections totaled $3 billion. VA is authorized by Public Law 105-33 to use all MCCF collections after June 1997 to increase VA's medical care budget. As a result, there are significant benefits to be recognized from improving MCCF collections.

By effectively implementing our previous recommendations, we projected that VHA could have increased collections by about $135 million in FY 2000 (24 percent). Additionally, clearing the backlog of un-issued medical care bills (that totaled over $1 billion as of September 30, 2001) would have resulted in additional collections of about $368 million. Our FY 2002 audit also reported that VA's average number of days to bill for services had increased to 95 days, in contrast to our FY 1998 audit that reported VAMCs averaged 48 days to bill for services. We also found that 77 percent of the related medical accounts receivable had no telephone follow-up, an increase of 12 percent in the number of accounts receivable that had no telephone follow-up in 1998.

Recommendations made in our July 1998 review of the MCCR program titled *Audit of the Medical Care Cost Recovery Program* (Report No. 8R1-G01-118) were not adequately implemented. Conditions identified during that audit, including missed billing opportunities, billing backlogs, and inadequate follow-up on accounts receivable, persist.

VA's Program Response

Over the past few years, the OIG issued several reports addressing VA's debt management activities. The OIG reported that VA should be more aggressive in collecting debts, improve debt avoidance practices, and streamline and enhance credit management and debt establishment procedures.

VA has made substantial progress in addressing the concerns reported by the OIG. For example, VA will meet its goals for referral of delinquent debt to the Department of the Treasury for administrative offset (TOP) and cross-servicing. Following are specifics as of June 2002:

			Percentage
TOP	Eligible for referral Referred	244,041,144 239,300,437	98%
Cross-Servicing	Eligible for referral Referred	180,251,605 172,607,493	96%

VA plans to reactivate the Income Verification Match (IVM) program in early FY 2003, with additional software enhancements anticipated in the third quarter. A directive will be published once the program is reactivated to provide specific performance requirements for staff responsible for billing activities; provisions for monitoring of Health Eligibility Center (HEC) referrals for means testing, billing, and collection activities; and evaluation of compliance with billing referrals within 60 days. The new VHA Business Office, established in May 2002, will monitor the IVM project and HEC's performance; however, not all referred cases are billable to insurance carriers. Regarding the means test process, the new Chief Business Officer has ordered a full review of this process. Significant changes are anticipated, which could make centralization of means testing unnecessary. Work on the centralized means testing has been suspended pending the results of the review and redesign of the process.

VA is taking action to implement the recommendations in the OIG's report on the MCCF program as well as to improve billing, collection, and follow up on accounts receivable. In September 2001, VHA published a revenue cycle improvement plan to serve as a comprehensive guide in defining VHA's vision in recognizing the key role that third-party collections play in overall systems operations. To assist in performance assessment, four different diagnostic measures reports are compiled on a monthly basis and reviewed by VHA's National Leadership Board (NLB). The reports provide comparative network profiles of completed registration percentages, insurance verification status updates, outpatient billing lag times, and inpatient billing lag times. Other monthly reports are prepared for the NLB that focus on specific billing and collection activities. These reports

are also made available to network and facility directors to assess how each facility compares in program-specific collection activities. The VHA Health Information Management Handbook is planned for completion in December 2002 and addresses all issues related to medical records and documentation. In addition, nationally developed documentation templates, additional nationally developed electronic encounter forms, and physician documentation education tools were released in September 2002.

MCCF/Revenue collections from FY 1997 through FY 2001 totaled $3 billion. The FY 2001 collections of $771 million is a 35 percent increase over the FY 2000 collections of $573 million. The FY 2002 original budgeted collections goal was $1.050 billion; current cumulative collections are now projected to be $1.070 billion, 20 percent more than the budgeted goal. The end of year 2002 cumulative collections ($1.176 billion) are 53 percent over the FY 2001 collections.

When reasonable charges were implemented in September 1999, VHA Revenue and Health Information Management Systems (HIMS) staff had to confront additional requirements for identifying, documenting, and coding episodes of care. Claims are now prepared for separate professional services as well as facility services, resulting in multiple claims being generated for inpatient stays and outpatient visits. Although much progress has been made, the Revenue Office, now part of VHA's Business Office, and many field organizations believe that significant amounts of revenue have yet to be captured.

The VHA Revenue Office entered into a contract for a study to examine the performance of hospital processes associated with third-party revenues generated from inpatient professional services. The study makes a detailed examination of the revenue operations in one network for the purpose of identifying and documenting reasons that billing for professional services is below expectations. This research focuses on the critical link between revenues and whether professional services have been adequately documented, coded, and then captured by billing staff for preparation of third-party claims.

The Revenue Office estimates that potential revenues from inpatient professional services are $71.4 million for FY 2001. Of this amount, $20.9 million had been billed and collected at the time of the study, leaving $50.6 million unbilled. Of that potential total unbilled amount across all 21 networks, $36.7 billion (73 percent) was estimated to be unbillable for lack of appropriate documentation or other reasons. Insufficient documentation is the most significant reason that otherwise billable professional services cannot be claimed.

The Under Secretary for Health released a memorandum, dated May 22, 2002, to VHA facilities that directed them to contract out all aged receivables over 60 days old to a collection agency. This memorandum also recommended that facilities report actions being taken to implement this direction and report back to the Network Chief Financial Officer within 60 days of the memorandum.

9. Procurement Practices

The Department spends about $6 billion annually for pharmaceuticals, medical and surgical supplies, prosthetic devices, information technology, construction, and services. VA faces major challenges to implement a more efficient, effective, and coordinated acquisition program. High-level management support and oversight are needed to ensure VA leverages its full buying power and maximizes the benefits of competitive procurements. VA supply inventory practices must ensure that adequate quantities of medical and other supplies are available to meet operating requirements while avoiding excess inventories that tie up funds and other resources that could be used to meet other VA needs.

In June 2001, the Secretary established a procurement reform task force to review VA's procurement programs, address concerns about acquisition practices, and develop recommendations for improvement. The task force recommended 60 specific reforms to achieve the goals of:

(i) leveraging the Department's purchasing power by requiring VA facilities and networks to make purchases under a prescribed hierarchy of nationally negotiated contracts; (ii) expanding joint purchases with the DoD; (iii) increasing standardization of commonly used commodities; (iv) improving the usefulness of procurement systems and data; (v) increasing top management oversight of VA procurement activities; (vi) improving Government purchase card controls; and (vii) improving acquisition workforce training, recruitment and retention. The reforms recommended by the task force were implemented at the direction of the Secretary.

The OIG reviews have continued to identify ongoing problems with Federal Supply Schedule purchases, pre-award and post-award contract reviews, inventory management, purchase cards, scarce medical specialist/sharing contracts, and the fee-basis program. We continue to conduct contract audit and drug pricing reviews to detect defective and excessive pricing.

9.A. OIG Issue - Federal Supply Schedule Purchases

Federal Supply Schedule (FSS) contracts are awarded non-competitively by VA's National Acquisition Center to multiple vendors for like or similar commercial off-the-shelf products. The Government's negotiation strategy is to obtain most favored customer pricing or better.

During the past few years, the effectiveness and integrity of the FSS program have deteriorated because FSS is no longer a mandatory source for these commercial products. The May 2002 Procurement Reform Task Force report recommended that VA establish a contract hierarchy that mandates the use of FSS for procurement of certain groups of health care supplies.

Current Status

OIG CAP reviews have identified non-competitive open-market purchases at higher prices than comparable items offered on FSS contracts. Our reviews have also identified sole source contracts that lack adequate business analyses, justifications, or cost/benefit assessments. Many contract proposals are not being audited and may not have been subjected to legal and technical reviews when required. Management attention is also needed to develop clear and useful policies that will ensure fair and reasonable prices, consistency in the use of VA's statutory authority, and proper oversight of such activities.

Because FSS contracts are not mandatory sources of supply, the number of VAMC open market purchases has increased. In many cases, these purchases were made without seeking competition or negotiating prices, or determining the reasonableness of the prices offered by vendors. In addition, some vendors have withdrawn high-volume or high-cost medical supply items from FSS contracts, refused to negotiate contract terms in good faith, canceled existing contracts, or declined to submit proposals to acquire FSS or VA national contracts.

Although these vendors do not have contracts, they continue to maintain their VA market share by selling open market to individual VAMCs, avoiding offering most favored customer prices, and shielding themselves from pre-award and post-award reviews.

VA's Program Response

The Office of Acquisition and Materiel Management (OA&MM), working closely with VHA's Clinical Logistics Office, has taken the lead in implementing the recommendations of the Secretary's Procurement Reform Task Force. OA&MM established a project tracking system to monitor the status/progress of the recommendations. Each recommendation has been assigned to a lead agent, who is responsible for implementing an action plan. Progress is monitored on a weekly basis by management officials in the Office of Management.

9.B. OIG Issue - Pre-Award and Post-Award Contract Reviews

Since FY 1993, the OIG has conducted pre-award and post-award reviews to provide contracting

officials with insight into each vendor's commercial sales and marketing practices as well as buying practices. These reviews provide contracting officers with information needed to strengthen the Government's pricing position during negotiations.

Current Status

The OIG continues to perform pre-award and post-award contract audits and drug pricing reviews to detect defective pricing in proposed and existing contracts. During the period October 2001 through March 2002, pre-award reviews of three FSS proposals resulted in OIG recommendations that could lead to cost savings of about $3 million. The manufacturers did not offer most favored customer prices to the FSS customers when those prices were extended to commercial customers purchasing under similar terms and conditions as the FSS. During the same period, post-award reviews of FSS vendors' contractual compliance resulted in recoveries of $21 million.

VA's Program Response

The Office of Acquisition and Materiel Management (OA&MM), working closely with VHA's Clinical Logistics Office, has taken the lead in implementing the recommendations of the Secretary's Procurement Reform Task Force. OA&MM established a project tracking system to monitor the status/progress of the recommendations. Each recommendation has been assigned to a lead agent, who is responsible for implementing an action plan. Progress is monitored on a weekly basis by management officials in the Office of Management.

9.c. OIG Issue - Inventory Management

The OIG conducted a series of five audits to assess inventory management practices for various categories of supplies. These audits found that VA medical centers maintained excessive inventories and made unnecessary large quantity purchases. Additionally, inventory security and storage deficiencies were found. An FY 1998 audit of medical supply inventories at five VAMCs found that at any given time the value of VHA-wide excess medical supply inventory was $64 million, 62 percent of the $104 million total inventory. An FY 1999 audit of pharmaceutical inventories at four VAMCs found that about 48 percent of the $2 million inventory exceeded current operating needs. An FY 2000 audit at five VAMCs concluded that 47 percent of the $3 million prosthetic supply inventory was not needed. An FY 2001 audit at five VAMCs concluded that 67 percent of the $5 million engineering supply inventory used for maintaining and repairing buildings, equipment, furnishings, utility systems, and grounds was not needed.

The main cause of the excess inventories was that the Generic Inventory Package, an inventory management system, was not used or was not used effectively to manage the inventories. VAMCs relied on informal inventory methods and cushions of excess stock as a substitute for structured inventory management.

Current Status

The last of the five OIG audits was completed in FY 2002 and assessed VA medical center management of miscellaneous supply inventories that included operating supplies (mainly housekeeping and dietetic items), office supplies, employee uniforms, and linens. The VAMCs reviewed had combined miscellaneous supply inventories valued at $3.5 million, $2.7 million (77 percent) of which was excess. Four VHA recommendations remain unimplemented in the FY 2000 report.

VA's Program Response

VHA Handbook 1761.2, *VHA Inventory Management,* was issued in response to the OIG's recommendations from the series of five audits conducted on inventory management. It requires each facility to implement an inventory management plan. Plans have been received from all of the networks, and VHA's Clinical Logistics Office is monitoring inventory management at each medical facility. To provide further instruction for reducing engineering supply inventories, VHA issued Information Letter 17-2002-001, *Engineering Inventory*. VHA's Pharmacy Benefits Management staff has worked diligently to educate field staff on the value and advantage of implementing a commercially supplied inventory

package adopted by VHA's primary drug source vendor. Amended VHA Handbook 1761.2 was published on September 25, 2002, and provides guidance for further improvement in pharmacy inventory management.

9.D. OIG Issue - Government Purchase Card Use

OIG audits and CAP reviews have identified significant vulnerabilities in the use of Government purchase cards. Purchases have been split to circumvent competition requirements, and goods and services have been acquired at excessive prices. Our reviews of purchase card records, invoices, purchase orders, procurement history files and other related records also lead us to believe that VHA is purchasing health care items on the open market in amounts greater than the 20 percent maximum allowed under Title 38 U.S.C. §8125(b)(3)(A).

Current Status

During the period February 1999 through March 2002, the OIG issued 58 reports, covering in part, Government purchase card program activities. Systemic issues were identified including deficiencies in: (i) account reconciliation and certification; (ii) competition and split purchases; (iii) Government purchase card use; (iv) accounting reviews and audits; (v) segregation of duties; and (vi) training and warrants. These conditions are a result of the widespread and essentially unmonitored use of Government purchase cards in conjunction with the decentralization of purchasing authority to VAMCs.

VA's Program Response

All procurements are posted to the Financial Management System (FMS), VA's accounting system, on a daily basis. This allows cardholders and program officials to closely monitor expenditures and to immediately identify items in dispute. Audits are routinely conducted on the program, including random statistical sampling conducted between the Financial Services Center transaction records and individual facility. The Financial & Systems Quality Assurance Service (FSQAS) provides oversight coverage of the purchase card program through financial management reviews. Local audits, conducted with finance and procurement managers, and numerous fiscal quality and OIG reviews are held throughout the year. Specifically, responsibilities of key participants are outlined in VA's Purchase Card Procedures Guide, dated February 1996, and VHA Purchase Card Handbook 1730.1, dated June 2000.

Additionally, a variety of management reports, which detail expenditures and card usage within an agency, are available to monitor use of the card. Program coordinators may also access transaction information online using VA's contracted electronic card management system, or, in the case of VHA coordinators, through the Integrated Funds Distribution, Control Point Activity, Accounting and Procurement (IFCAP).

Training on procurement and internal control procedures is mandatory for all cardholders and approving officials and must be conducted prior to issuance of the card. Additionally, with newly trained cardholders, approving officials and the instructor must verify the cardholder participation in the training session and sign a certification form, which may be used to designate spending limits for the card. The Head of Contracting Activity approves or disapproves card limit increase requests. Only the Agency/Organization Program Coordinator or designate is authorized to make changes in the contract bank electronic system.

The following are specific enhancements and initiatives taking place to improve the purchase card program –

- VA intends to hire a consultant to perform data mining on all purchase card transactions that have been split to circumvent competition requirements and cost threshold.
- VA's new purchase card policy directive will provide a single consistent guide for purchase card use.

The OIG has begun an audit to evaluate the effectiveness and efficiency of VA's purchase card program and is continuing to review purchase card activities on CAP reviews at VA facilities.

VHA is revising both the VHA Quality Assurance Review Handbook (1730.2) and the VHA Purchase Card Handbook (1730.1) to strengthen facility level quality reviews in order to detect violations of the purchase card and evaluate the responses of local management to these violations. Each month, card coordinators provide information on payment and order reconciliations, which are collected and widely distributed in a national spreadsheet with red/yellow/green indicators for the information and action of local and network management. All the cited OIG issues are due to the lack of adherence to policies in the current purchase card handbook, such as annual joint fiscal/logistics reviews of cardholders. Highlighting the performance of local management in surfacing and correcting violations should improve adherence to policy.

9.e. OIG Issue - Scarce Medical Specialist Contracts

OIG reviews of scarce medical specialist contracts have identified costs that were not fair and reasonable; conflict of interest issues; sole source contracts that lack adequate business analyses, justifications or cost/benefit assessments; and the lack of cost or pricing data in noncompetitive contracts. We also found that VAMCs were using Intergovernmental Personnel Act assignments and commercial items contracts inappropriately as a substitute for scarce medical specialist contracts. Use of these purchasing methods, in lieu of contracts, has resulted in higher prices for these services. Management needs to improve oversight to ensure that, when applicable, properly negotiated contracts are used. Furthermore, in order to obtain reasonable prices, management needs to develop and/or enforce policies that ensure consistent compliance with VA's statutory authority.

Current Status

From October 2000 through July 2002, we completed contract reviews of 21 health care resource contract proposals involving scarce medical specialist services. We concluded that VA contracting officers should negotiate reductions of over $7.5 million to the proposed contract costs.

Our CAP program reviews also conducted during this same period found that VAMCs did not have adequate assurance that contract prices were reasonable, some contract price negotiation memorandums were missing or never prepared, and other contracts did not ensure that a measurable statement of work was developed. Controls over contract documentation and justifications need to be strengthened, conflict of interest situations need to be eliminated, and adequate contract administration procedures should be implemented for service contracts.

VA's Program Response

With regard to OIG reviews of scarce medical specialist contracts, the Medical Sharing Office is developing a new policy to address issues identified during the reviews. An updated directive in the VHA Handbook 1660.3, *Conflict of Interest Aspects of Contracting for Scarce Medical Specialist Services, Enhanced Use Leases, Health Care Resource Sharing, Fee Basis and Intergovernmental Personnel Act Agreements* was issued in July 2002. A draft of the new directive for purchasing under enhanced sharing authority (38 USC § 8153) will be issued for concurrence by December 2002.

9.f. OIG Issue - Controls Over the Fee-Basis Program

We conducted an audit to determine if VHA had established effective internal controls to ensure that payments for fee-basis treatment were appropriate. Fee-basis treatment is inpatient care, outpatient care, or home health care provided by non-VA health care providers at VA expense. In June 1997, the OIG issued a report titled *Audit of Internal Controls over the Fee-Basis Program* (Report No. 7R3-A05-099) that found VHA could reduce fee-basis home health care expenditures by at least $1.8 million annually and improve the cost effectiveness of home health services by:

(i) establishing guidelines for contracting for such services, and (ii) providing contracting officers with benchmark rates for determining the reasonableness of charges.

Current Status

VHA has not implemented the OIG recommendations in the June 1997 report to establish guidelines for contracting and provide contracting officers with benchmark rates.

VA's Program Response

In response to the OIG's report on the fee-basis program, VHA is considering two reimbursement policies. One policy allows for Best Value contracts. The other is a proposed Federal regulation (Common Payer Platform) that would adopt Medicare rates as VA rates for all health care services, including contract home health care. VA is still examining the proposed regulation in light of its potential effect on reimbursement rates in certain geographic locations. In anticipation that Best Value contracts will be in place in most metropolitan areas and the Common Payer Platform in rural areas or areas with a low density of veterans, VHA is formulating policy to implement these provisions and developing templates and statements of work for programs under the umbrella of Home and Community-Based Care with the Office of Clinical Logistics. VHA is also working on an expanded reimbursement policy for Homemaker/Home Health Aide for those low-density areas not covered by Best Value contracts. Pricing guidance for non-Medicaid States is also under development and VA is working with the Centers for Medicare and Medicaid Services on these issues.

10. Human Capital Management

Human capital management (HCM) is a major challenge for the Department. Given the significant size of VA's workforce and the high number of employees projected to become retirement eligible over the next 5 years, there is urgency to address this challenge effectively.

Current Status

The VA Office of Human Resources Management (HRM) reported in FY 2001 that registered nurses are the largest segment of health care workers within the Department. VA employs approximately 35,000 registered nurses and nurse anesthetists. VAMCs are having difficulty recruiting nurses in specialty fields. Some VAMCs find it difficult to recruit and retain licensed practical nurses and nursing assistants. According to HRM, 12 percent of the VA nursing population is eligible to retire now and approximately 4 percent more will be eligible to retire each year thereafter. Also, current recruitment processes do not provide sufficient flexibility to make timely employment offers to fill many critical positions.

As part of the Department's FY 2003 budget, VA reported that close to 50 percent of the Department's workforce and over 90 percent of the senior executives will be eligible for optional or early out retirement by FY 2005. The *Department of Veterans Affairs Workforce and Succession Plan* identifies cross-cutting issues in need of focus at the Department level and will complement the work being done at the administration and staff office levels.

VHA formed a national succession planning task force to address their changing workforce. According to the task force's August 2001 draft report, "VHA faces a leadership crisis unprecedented in its history. It is paramount that we quickly focus on both developing our new leaders as well as replacing key employees throughout our organization." The task force's draft report lists recommendations in seven major categories: (i) benchmarking; (ii) workforce assessment; (iii) employee morale and satisfaction; (iv) short-term steps; (v) progression planning; (vi) legislative initiatives; and (vii) organizational infrastructure.

The OIG has not issued recent national audits on HCM; however, we have identified resource shortages in CAP reviews.

VA's Program Response

A VHA Nursing Workforce Workgroup was chartered in September 2000. Their report, "A Call to Action," provides a comprehensive summary of current and future trends for VA nursing, with multiple recommendations in the areas of utilization, recruitment, retention, and outreach. This report provides a strong framework for addressing a nursing workforce agenda for VHA. Additionally, Public Law 107-135 established the National Commission on VA Nursing. This commission has met twice. It will exist for 2 years and is mandated to study and recommend legislative and organizational changes to enhance recruitment and retention of nurses. It will also assess the future of nursing within VA. "A Call to Action" is a sound foundation for the Commission's work.

The Title 38 employment system for healthcare professionals offers significant improvements in timeliness of hiring compared to the Title 5 system. The Title 38 excepted hiring authority applies to healthcare occupations such as nurses, physicians, pharmacists, and licensed practical nurses, but not to nursing assistants and many other healthcare occupations such as radiology technicians, medical machine technicians, and technologists. Additional actions that are being taken include:

- Integration of workforce and succession planning into VISNs' (the VHA operational organizations responsible for geographical service areas) annual strategic planning process to ensure that key issues are integrated into VHA's annual strategic plan. A formal Web-based workforce strategic planning template was established and used for the FY 2003 planning cycle. VISNs completed a comprehensive and detailed workforce and diversity assessment, developed workforce/diversity strategies and plans to support current and future programs, and submitted their workforce/diversity plans as a component of their overall annual strategic plan. A multi-disciplinary team is developing the national VHA workforce/diversity plan based on VISN plans. This national workforce/diversity plan will update VHA's original succession plan and will continue as a part of VHA's annual strategic planning process.
- Strategies to act on the results of the 2001 all-employee survey. VHA will continually assess and develop instruments that consistently measure, analyze, and improve employee satisfaction. Focusing on reducing or minimizing areas of dissatisfaction and accentuating motivators is key to our succession efforts. VHA established the National Center for Organizational Development to provide the expertise and support to management to continually improve the working environment and increase productivity. To date, in partnership with other VHA expert staff, comprehensive organizational profiles have been developed using information from two all-employee surveys combined with information on organizational culture and other information reflecting employee satisfaction and morale. These profiles are being presented to VISN management teams along with recommended strategies. This information will be made available to all VHA employees through VA's Intranet. VISNs and VHA headquarters offices will develop and implement action plans that will be incorporated into their annual strategic workforce plans in the next planning cycle. Progress will be tracked through recurring employee assessments along with monitors of other indicators of employee satisfaction such as number of EEO cases, Unfair Labor Practice complaints, and occupational injuries. An automated, Web-based system for conducting employee surveys and assessments has been implemented.
- VHA developed a Succession Planning Web site; it contains information on all VHA succession planning programs and efforts, a library of HR tools and practices to communicate to and assist management in fully utilizing HR tools and policies currently available, and a library of succession planning-related information including links to related Web sites.

- Implemented a comprehensive leadership development program based on VHA's High Performance Development Model. Under this program, high potential employees will continually be identified at the local, network, and national levels. In a structured program, these high potential employees will be provided a mentor, a personal development plan, and both formal and informal learning experiences and opportunities. These employees will be selected competitively each year and tracked as they progress through the organization. Knowledge transfer and retention strategies will be an integral component of all workforce succession efforts including both personal and Web-based/e-learning coaching and mentoring programs. Increasingly, retired employees will be invited to serve in mentoring and teaching roles with compensation provided for time, travel, and other expenses. VHA continues to expand its leadership program offerings.

VA submitted a Restructuring Plan to the Office of Management and Budget (OMB) in September 2002. In response to the plan, OMB gave VA a score of "green" for progress in implementing the President's Management Agenda item, Human Capital Planning, on their scorecard. The plan contains a series of strategies that identify a corporate approach to workforce planning, and the Office of Human Resources and Administration is working closely with VA's Administrations and key VACO senior officials to implement the strategies. In addition, VA established a Workforce Planning Council to ensure that workforce planning at all organizational levels links to VA's strategic planning process. The council also affords an opportunity to identify cross-cutting workforce planning issues and develop appropriate strategies to address them at the Department level. VA is also working to improve its recruitment and marketing efforts through expanded outreach programs and a redesign of the VA recruitment Web site.

Management Challenges Identified by the General Accounting Office

In January 2001, GAO issued its special series of reports entitled the *Performance and Accountability Series: Major Management Challenges and Program Risks (GAO-01-241),* which described major management challenges and high-risk areas facing Federal agencies. The following is excerpted from the October 2002 report entitled *Performance and Accountability: Reported Agency Actions and Plans to Address 2001 Management Challenges and Program Risks (GAO-03-225)* in which GAO examined Federal agency 2001 performance reports and 2003 performance plans to determine how they addressed the high-risk areas and major management challenges identified in the January 2001 series of reports. The report can be viewed in its entirety at the GAO Web Site: http://www.gao.gov/cgi-bin/getrpt?GAO-03-225.

1. Strategic Human Capital Management

(a GAO-designated governmentwide high risk)

GAO has identified shortcomings at multiple agencies involving key elements of modern strategic human capital management, including strategic human capital planning and organizational alignment; leadership continuity and succession planning; acquiring and developing a staff whose size, skills, and deployment meet agency needs; and creating results-oriented organizational cultures.

We found that VA faces a potential shortage of skilled nurses, which could have a significant effect on VA's quality of care initiatives. VA also needs to be vigilant in its human capital strategies to ensure that it maintains the necessary expertise to process claims as newly hired employees replace many experienced claims processors over the next 5 years.

Current Status and Future Plans

Progress in resolving major management challenges as discussed in agency's FY 2001 performance report:

In response to the President's Management Agenda, VA reported that it has developed a human capital workforce and succession plan, which articulates

specific strategies to address recruitment, retention, and development issues. For example, to help retain a skilled and competent workforce, VA developed a childcare tuition assistance program for lower-income employees.

In addition, VA reported that it is engaged in multiple efforts to assess its current nursing workforce and plan for the future. For example, a workgroup reported on the effect of the nursing shortage and barriers to recruitment and retention of nurses. The report contains a reference guide for the optimal use of hiring and pay authorities and recommends legislative and non-legislative initiatives to address the nursing shortage.

Finally, VA reported that it launched a centralized training initiative—the standard for training future hires—for veterans service representatives, who request and obtain information on and evaluate veterans claims and assign a disability rating.

Applicable goals, measures, and strategies as discussed in agency's FY 2003 performance plan:

VA reported that the overall goal of its workforce planning initiative is to create an ongoing process—integrated with VA's strategic and budget planning cycles—to predict future workforce trends and avert potential workforce crises. VA has developed an "interim" objective—and related performance measures and targets—to recruit, develop, and retain a competent, committed, and diverse workforce that provides high-quality service to veterans and their families.

VA reported that the national nursing shortage continues to be a priority for the health care industry, although there is no indication that the quality of care in VA medical centers has been adversely affected by this shortage. VA plans to maintain an active recruitment process, and legislation authorizing higher salaries for VA nurses should help these efforts. However, VA does not describe other strategies for addressing this shortage.

VA also reported that it plans to test national performance standards for claims processors.

2. Information Security

(a GAO-designated governmentwide high risk)

Our January 2001 high-risk update noted that agencies' and governmentwide efforts to strengthen information security have gained momentum and expanded. Nevertheless, recent audits continue to show federal computer systems are riddled with weaknesses that make them highly vulnerable to computer-based attacks and place a broad range of critical operations and assets at risk of fraud, misuse, and disruption. Further, the events of September 11, 2001, underscored the need to protect America's cyberspace against potentially disastrous cyber attacks—attacks that could also be coordinated to coincide with physical terrorist attacks to maximize the impact of both.

Current Status and Future Plans

Progress in resolving major management challenges as discussed in agency's FY 2001 performance report:

VA continues to report information security controls as a material weakness on its Federal Managers Financial Integrity Act (FMFIA) report for 2001. Similarly, the VA Office of Inspector General (OIG) reported widespread weaknesses in computer security.

To improve the Department's information security program, VA reported that it met its 2001 target to have 20 percent of the Departmentwide information security program implemented. VA reported that the Office of Cyber Security undertook numerous efforts, including

- developing and issuing a revised VA Information Security Management Plan, which identified security enhancement actions,
- establishing a central security fund to consistently pursue Departmentwide security efforts,
- implementing an enterprise-wide integrated antivirus solution that will facilitate the rapid distribution of antivirus updates to more than 150,000 VA desktops and servers at over 800 locations,

- initiating a contract to develop a certification and accreditation program to bring discipline, formality, and technical excellence to the security planning activities of VA offices during the design of systems and applications,
- providing VA facilities access to a single security incident response service to which they can report security incidents and receive advice related to scope, effect, and suggested remedies,
- establishing a national program in security training and education of computer professional staff,
- beginning to revamp security policies into usable frameworks, and
- developing and submitting to OMB the Government Information Security Reform Act (GISRA) report and corrective action plans.

Applicable goals, measures, and strategies as discussed in agency's FY 2003 performance plan:

For 2003, VA's information security measure and target is to have 100 percent of GISRA reviews and reporting completed. Further, VA reported that its efforts to revamp security policies into a usable framework is still ongoing.

However, this measure may not specifically gauge the effectiveness of information security and the agency's progress in implementing corrective actions. The National Institute of Standards and Technology (NIST) developed a security assessment framework and related tools that agencies can use in determining the status of their information security programs. Also, the Office of Management and Budget (OMB) guidance for 2002 reporting under GISRA requires agencies to use tools developed by NIST for evaluating the security of unclassified systems or groups of systems. In addition, OMB's GISRA reporting guidance requires specific performance measures, as well as corrective action plans with quarterly status updates.

3. Ensure timely and equitable access to quality VA health care

(a GAO-designated major management challenge)

VA cannot ensure that veterans receive timely care at VA medical facilities. Nor can it ensure that it has maintained the capacity to provide veterans who have spinal cord injuries, serious mental illnesses, or other special needs the care that they require, as mandated by the Congress. VA must also assess its capacity to provide long-term care for its aging veteran population and respond to emerging health care needs, such as treating veterans for hepatitis C.

Current Status and Future Plans

Progress in resolving major management challenges as discussed in agency's FY 2001 performance report:

In 2001, VA reported that it established baselines for two of its waiting time performance goals: scheduling patients for non-urgent primary care and specialty care visits within 30 days. VA's third waiting time goal—to have 73 percent of patients seen within 20 minutes of their scheduled appointment—was not met overall, but half of VA's 22 networks exceeded the goal. (Early in 2002, VA combined two networks and now has 21.)

VA reported that it exceeded its goal to maintain at 95 percent the proportion of discharges from spinal cord injury centers to noninstitutional settings. VA also reported that it met its goal to have 63 percent of homeless veterans with mental illness receive follow-up mental health outpatient care or admission to a work, transitional, or rehabilitation program. VA did not establish a target for its one hepatitis C measure, but it said that it did not achieve its hepatitis C goal. Regarding long-term care, VA is conducting a 3-year pilot study of assisted living and plans to report the outcomes to the Congress in 2004.

Applicable goals, measures, and strategies as discussed in agency's FY 2003 performance plan:

VA set the performance goal to increase the percent of primary care and specialty care appointments scheduled within 30 days of desired date to 89

percent and 87 percent (from 87 and 84 percent), respectively. For its third waiting time goal, VA established a 2003 target of 72 percent. Efforts described focus on improving the quality of the data used to measure performance.

VA's 2003 performance target related to care for veterans with spinal cord injuries remains at 95 percent. Its performance target for caring for homeless veterans with mental illness also remains at the 2001 target of 63 percent; however, its strategic target for this goal is 68 percent. VA established three new measures for caring for veterans with hepatitis C as well as targets for two of these measures: the 2003 performance target for percentage of all patients screened and percentage of all patients tested for hepatitis C is 61 percent and 65 percent, respectively, with strategic targets set at 80 percent and 82 percent. The 2003 performance target and strategic target for the third measure—percentage of patients with hepatitis C who have annual assessment of liver function—are to be determined. While VA acknowledges GAO's concern regarding long-term care, its strategy for ensuring adequate capacity is not addressed in its 2003 performance plan.

4. Maximize VA's ability to provide health care within available resources

(a GAO-designated major management challenge)

VA must continue to aggressively pursue opportunities to use its health care resources. VA could achieve more efficiencies by further modifying its infrastructure to support its increased reliance on outpatient health care services, expanding its use of alternative methods for acquiring support services, and pursuing additional opportunities with the Department of Defense (DoD) to determine cost-effective ways to serve both veterans and military personnel. In addition, VA must ensure that it collects the money it is due from third-party payers.

Current Status and Future Plans

Progress in resolving major management challenges as discussed in agency's FY 2001 performance report:

VA's report addresses two of these concerns—capital asset management and procurement reform—under its "enabling goal," which aims to create an environment that fosters the delivery of "world-class" VA services. The enabling goal has no key performance measures. VA reported that its Capital Asset Realignment for Enhanced Services (CARES) program is ongoing. VA reported that its Procurement Reform Task Force, formed in July 2001, established five major goals: leverage purchasing power, standardize commodities, obtain comprehensive VA procurement information, improve VA procurement organizational effectiveness, and ensure sufficient and talented acquisition workforce.

VA also reported that in May 2001, the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans was established. The task force's mission is to identify ways to improve benefits and services for DoD military retirees who are also VA beneficiaries, review barriers and challenges that impede VA and DoD coordination, and identify opportunities for improved resource utilization through partnerships.

In addition, VA reported that its Revenue Enhancement Work Group and Steering Committee identified 24 major recommendations that require action in order to bring VA's revenue operation to the next level of success in improving third-party collections.

Applicable goals, measures, and strategies as discussed in agency's FY 2003 performance plan:

In its 2003 plan, VA established a performance goal of attaining a 30 percent cumulative reduction in excess capacity as a result of the implementation of CARES. The national CARES plan will identify total excess capacity. VA reports that this first phase of CARES, implementing the program in the Network 12, will take 5 years or more.

VA established the performance goal of increasing the number and dollar volume of sharing agreements with DoD by 10 percent over the previous year. This sharing includes joint procurement activities as well as sharing resources. The 2003 plan reiterates the creation of

the President's task force but does not provide an update on the task force's progress.

While VA's 2003 plan notes that it has undertaken several initiatives to address third-party collections weaknesses, it does not have a performance measure for third-party collections. Moreover, it does not report on the status of the Revenue Enhancement Work Group and Steering Committee's 24 recommendations.

5. Process veterans' disability claims promptly and accurately

(a GAO-designated major management challenge)

VA has had longstanding difficulties in ensuring timely and accurate decisions on veterans' claims for disability compensation. Veterans have also raised concerns that claims decisions are inconsistent across VA's regional offices. VA needs better analyses of its processes in order to target error-prone types of cases and identify processing bottlenecks—as well as determine if its performance goals are realistic.

Current Status and Future Plans

Progress in resolving major management challenges as discussed in agency's FY 2001 performance report:

VA reported that it exceeded its 2001 timeliness goal to complete rating-related actions on compensation and pension claims on average within 202 days; however, this performance was worse than the previous year's—a trend VA characterized as "unacceptable." VA also reported exceeding its goal of a national accuracy rate of 72 percent. The 2001 rate of 78 percent was significantly better than the 2000 rate of 59 percent.

Applicable goals, measures, and strategies as discussed in agency's FY 2003 performance plan:

VA set its 2003 timeliness target at 165 days, and its strategic target at 74 days. (The Secretary set a goal of an average of 100 days processing time for the last quarter of 2003.) However, for 2002, VA projected that it would take an average of 208 days to process rating-related actions—27 days more than in 2001. Conversely, the accuracy rate for VA's claims processing was expected to continue to improve. For 2002, VA projected that the rate would be 85 percent. VA's 2003 target is 88 percent, and its strategic target is 96 percent.

VA has numerous initiatives planned for 2003 aimed at improving claims processing. These initiatives focus on automation, training, performance assessment, and program evaluation.

6. Develop Sound Agency-Wide Management Strategies to Build a High-Performing Organization

(a GAO-designated major management challenge)

VA must revise its budgetary structure—to link funding to performance goals, rather than program operations—and develop long-term, agency-wide strategies for ensuring an appropriate IT infrastructure and sound financial management.

Current Status and Future Plans

Progress in resolving major management challenges as discussed in agency's FY 2001 performance report:

VA reported that it and OMB jointly developed a proposal to restructure and simplify VA's budget accounts and to base its budgeting on performance. VA plans to implement the proposal with the 2004 budget.

In 2001, VA also reported that it made numerous advances regarding its enterprise architecture, including creating the Office of the Chief Architect, developing and issuing the *One VA* enterprise architecture strategy and implementation plan, and organizing and developing the Information Technology Board.

In addition, VA reported that it received an unqualified opinion on the consolidated financial statements for 2000 and 1999. VA also made progress in correcting material weaknesses in numerous areas and committed to addressing the remaining weaknesses.

Applicable goals, measures, and strategies as discussed in agency's FY 2003 performance plan:

Discussions of the details of the new structure for the budget accounts are ongoing with OMB and congressional appropriations committees. The 2003 plan states that VA intends to implement the new account structure with the 2004 budget. However, VA continues to work with OMB and has yet to delineate specific measures for this goal.

VA's 2003 plan identifies milestones for its IT approach and implementation—part of VA's enabling goal. VA also set one IT measure and target: 100 percent of Chief Information Officer-designated major IT systems conform to the *One VA* enterprise architecture.

VA's plan acknowledges the significant material weaknesses identified by its OIG and by GAO, such as noncompliance with FFMIA requirements, but does not have goals, measures, or strategies for addressing these weaknesses. Corrective actions needed to address noncompliance are expected to take several years to complete. In addition, the risk of materially misstating financial information remains high because of the need to perform extensive manual compilations and extraneous processes.